



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
3/29/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Hometown Insurance Agency of L.I., Inc. 5 Orville Dr. Suite 400 Bohemia, NY 11716  License#: 739962 HARLWIZ-01	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2"><b>CONTACT NAME:</b></td> </tr> <tr> <td>PHONE (A/C, No. Ext):</td> <td>FAX (A/C, No): 631-589-0164</td> </tr> <tr> <td colspan="2">E-MAIL ADDRESS: certs@hometowninsurance.com</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:80%;">INSURER(S) AFFORDING COVERAGE</th> <th style="width:20%;">NAIC #</th> </tr> </thead> <tbody> <tr> <td>INSURER A: HDI Global Insurance Company</td> <td>41343</td> </tr> <tr><td>INSURER B:</td><td></td></tr> <tr><td>INSURER C:</td><td></td></tr> <tr><td>INSURER D:</td><td></td></tr> <tr><td>INSURER E:</td><td></td></tr> <tr><td>INSURER F:</td><td></td></tr> </tbody> </table>	<b>CONTACT NAME:</b>		PHONE (A/C, No. Ext):	FAX (A/C, No): 631-589-0164	E-MAIL ADDRESS: certs@hometowninsurance.com		INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A: HDI Global Insurance Company	41343	INSURER B:		INSURER C:		INSURER D:		INSURER E:		INSURER F:	
<b>CONTACT NAME:</b>																					
PHONE (A/C, No. Ext):	FAX (A/C, No): 631-589-0164																				
E-MAIL ADDRESS: certs@hometowninsurance.com																					
INSURER(S) AFFORDING COVERAGE	NAIC #																				
INSURER A: HDI Global Insurance Company	41343																				
INSURER B:																					
INSURER C:																					
INSURER D:																					
INSURER E:																					
INSURER F:																					

**COVERAGES                      CERTIFICATE NUMBER: 1313558240                      REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR YRFD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y		██████████	12/31/2023	12/31/2024	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000 \$
A	<input type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY			██████████	12/31/2023	12/31/2024	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> <b>UMBRELLA LIAB</b> <input type="checkbox"/> EXCESS LIAB OCCUR CLAIMS-MADE OED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
 Venue: Somers High School, 120 Primrose Street, Lincolndale, NY 10540  
 Date of Event: 5/10/24

When required by written contract, Somers Central School District is included as an additional insured. Coverage is written on a primary and non-contributory basis and includes a waiver of subrogation in favor of additional insured. Subject to policy terms and conditions.

<b>CERTIFICATE HOLDER</b>  Somers Central School District 250 Route 202 Somers, NY 10589	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.  AUTHORIZED REPRESENTATIVE <i>Rubina Rahman</i>
--	--

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**ADDITIONAL INSURED – DESIGNATED  
PERSON OR ORGANIZATION**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

**SCHEDULE**

<b>Name Of Additional Insured Person(s) Or Organization(s)</b>
Any person or organization that you have agreed to include as an additional insured under an insured contract provided such contract was executed prior to the date of loss.
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

**Section II – Who Is An Insured** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

- A. In the performance of your ongoing operations; or
- B. In connection with your premises owned by or rented to you.

*This Endorsement changes the Policy. Please read it carefully.*

## COMMERCIAL GENERAL LIABILITY ENDORSEMENT

### PRIMARY AND NON-CONTRIBUTORY AMENDATORY – E1602AJ-1112

---

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART  
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

#### SCHEDULE

Name of Person Or Organization
Any person or organization that you have agreed to include as an additional insured under an insured contract provided such contract was executed prior to the date of loss.
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

**SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS**, paragraph 4. **Other Insurance** is hereby deleted and replaced with the following:

#### 4. Other Insurance

If other valid and collectible insurance is available to the insured for a loss we cover under Coverages **A** or **B** of this Coverage Part, our obligations are limited as follows:

##### a. Primary Insurance

This insurance is primary except when Paragraph **b.** below applies. If this insurance is primary, our obligations are not affected unless any of the other insurance is also primary. Then, we will share with all that other insurance by the method described in Paragraph **c.** below. However, with respect to any other valid and collectible insurance available to a person or organization as scheduled above, this insurance shall be primary to other available sources, except where the liability of such person or organization is caused by his, her, or its own negligence. Nothing herein shall be construed to make this Policy subject to the terms, definitions, conditions and limitation of any other insurance.

##### b. Excess Insurance

(1) This insurance is excess over:

(a) any of the other insurance, whether primary, excess, contingent or on any other basis:

- (i) that is Fire, Extended Coverage, Builder's Risk, Installation Risk or similar coverage for "your work";
- (ii) that is Fire insurance for premises rented to you or temporarily occupied by you with permission of the owner;

---

All other terms and conditions of the Policy remain unchanged

- (iii) that is insurance purchased by you to cover your liability as a tenant for "property damage" to premises rented to you or temporarily occupied by you with permission of the owner; or
  - (iv) if the loss arises out of the maintenance or use of aircraft, "autos" or watercraft to the extent not subject to Exclusion **g.** of Section **I – Coverage A – Bodily Injury And Property Damage Liability.**
- (b) any other primary insurance available to you covering liability for damages arising out of the premises or operations, or the products and completed operations, for which you have been added as an additional insured by attachment of an endorsement.
- (2) When this insurance is excess, we will have no duty under Coverages **A** or **B** to defend the insured against any "suit" if any other insurer has a duty to defend the insured against that "suit". If no other insurer defends, we will undertake to do so, but we will be entitled to the insured's rights against all those other insurers.

**c. Method Of Sharing**

In the instance where we are primary, we will be non-contributory. In any other instance, we will contribute as follows:

If all of the other insurance permits contribution by equal shares, we will follow this method also. Under this approach each insurer contributes equal amounts until it has paid its applicable limit of insurance or none of the loss remains, whichever comes first.

If any of the other insurance does not permit contribution by equal shares, we will contribute by limits. Under this method, each insurer's share is based on the ratio of its applicable limit of insurance to the total applicable limits of insurance of all insurers.

- (1) When this insurance is excess over other insurance, we will pay only our share of the amount of the loss, if any, that exceeds the sum of:
- (a) The total amount that all such other insurance would pay for the loss in the absence of this insurance; and
  - (b) The total of all deductible and self-insured amounts under all that other insurance.
- (2) We will share the remaining loss, if any, with any other insurance that is not described in this Excess Insurance provision and was not bought specifically to apply in excess of the Limits of Insurance shown in the Declarations of this Coverage Part.

POLICY NUMBER: [REDACTED]

COMMERCIAL GENERAL LIABILITY  
CG 24 04 05 09

# WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART  
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

### SCHEDULE

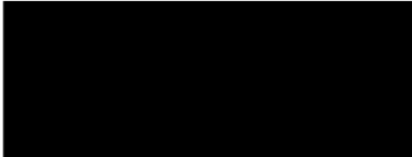
<p><b>Name Of Person Or Organization:</b> Any person or organization that you have agreed to include as an additional insured under an insured contract provided such contract was executed prior to the date of loss.</p>
<p>Information required to complete this Schedule, if not shown above, will be shown in the Declarations.</p>

The following is added to Paragraph 8. **Transfer Of Rights Of Recovery Against Others To Us** of Section IV – Conditions:


We waive any right of recovery we may have against the person or organization shown in the Schedule above because of payments we make for injury or damage arising out of your ongoing operations or "your work" done under a contract with that person or organization and included in the "products-completed operations hazard". This waiver applies only to the person or organization shown in the Schedule above.



**CERTIFICATE OF WORKERS' COMPENSATION INSURANCE**


\*\*\*\*\*



SCAN TO VALIDATE  
AND SUBSCRIBE

<p>POLICYHOLDER</p> 	<p>CERTIFICATE HOLDER</p> <p>SOMERS CENTRAL SCHOOL DISTRICT 250 ROUTE 202 SOMERS NY 10589</p>
---	---

<p>POLICY NUMBER</p> 	<p>CERTIFICATE NUMBER</p> 	<p>POLICY PERIOD</p> <p>07/01/2023 TO 07/01/2024</p>	<p>DATE</p> <p>4/4/2024</p>
--	---	--	-----------------------------

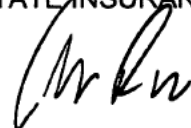
THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO.  COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

**IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.**

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

BY CAUSING THIS CERTIFICATE TO BE ISSUED TO THE CERTIFICATE HOLDER, THE POLICYHOLDER UNDERTAKES TO PROVIDE THE CERTIFICATE HOLDER 30 CALENDAR DAYS' NOTICE OF ANY CANCELLATION OF THE POLICY.

NEW YORK STATE INSURANCE FUND



DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 



CERTIFICATE OF INSURANCE COVERAGE
NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)
1b. Business Telephone Number of Insured
1c. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of Entity Requesting Proof of Coverage
3a. Name of Insurance Carrier
3b. Policy Number of Entity Listed in Box "1a"
3c. Policy effective period

4. Policy provides the following benefits:
5. Policy covers:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.

Date Signed 4/10/2024 By [Signature]
Telephone Number 516-829-8100 Name and Title Richard White, Chief Executive Officer

IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4B, 4C or 5B have been checked)

State of New York Workers' Compensation Board
According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law(Article 9 of the Workers' Compensation Law) with respect to all of their employees.
Date Signed By
Telephone Number Name and Title

Please Note: Only insurance carriers licensed to write NYS disability and paid family leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.



## Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box 3 on this form is certifying that it is insuring the business referenced in Box 1a for disability and/or Paid Family Leave benefits under the NYS Disability and Paid Family Leave Benefits Law. The insurance carrier or its licensed agent will send this Certificate of Insurance Coverage (Certificate) to the entity listed as the certificate holder in Box 2.

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is cancelled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in Box 3c, whichever is earlier.

This Certificate is issued as a matter of information only and confers no rights upon the certificate holder. This Certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This Certificate may be used as evidence of a NYS disability and/or Paid Family Leave benefits contract of insurance only while the underlying policy is in effect.

**Please Note: Upon the cancellation of the disability and/or Paid Family Leave benefits policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Insurance Coverage for NYS disability and/or Paid Family Leave Benefits or other authorized proof that the business is complying with the mandatory coverage requirements of the NYS Disability and Paid Family Leave Benefits Law.**

### NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

#### §220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.